Reprinted
April 12, 2001

ENGROSSED
HOUSE BILL No. 1727

DIGEST OF HB 1727 (Updated April 11, 2001 2:55 PM - DI 98)

Citations Affected: IC 4-6; IC 12-10; IC 12-15; IC 12-17.6; noncode.

Synopsis: Medicaid and human services. Establishes the public assistance programs investigative unit within the office of the attorney general to investigate abusive and improper or fraudulent practices in the public assistance programs administered by the office of the secretary of family and social services (FSSA). Requires that an individual who is participating in the community and home options to institutional care for the elderly and disabled (CHOICE) program receive services under a Medicaid waiver, if eligible. Requires FSSA to apply for a federal Medicaid waiver to require enrollees in Medicaid and the children's health insurance program (CHIP) who reside in certain counties to enroll in the risk-based managed care program and, if the waiver is approved, to implement mandatory enrollment in the risk-based managed care program. Increases the assessment on certain ICF/MR facilities from 5% of the facility's annual gross residential services revenue to 6%. Requires the office of Medicaid policy and

(Continued next page)

Effective: Upon passage; January 1, 2001; July 1, 2001.

Crawford, Friend, Kuzman, Aguilera

(SENATE SPONSORS — JOHNSON, MILLER, SIMPSON, BREAUX)

January 17, 2001, read first time and referred to Committee on Ways and Means.
February 14, 2001, amended, reported — Do Pass.
February 19, 2001, read second time, amended, ordered engrossed.
February 20, 2001, engrossed.
February 21, 2001, read third time, passed. Yeas 95, nays 2.

SENATE ACTION

March 5, 2001, read first time and referred to Committee on Finance.
April 5, 2001, amended, reported favorably — Do Pass.
April 11, 2001, read second time, amended, ordered engrossed.

Digest Continued

planning (OMPP) to develop a disease management program to study the provision of health care services to Medicaid recipients with chronic diseases, the cost of those services, and alternative methods of service delivery to provide necessary services at reduced cost. Requires OMPP to report to the health finance commission and the budget committee regarding the disease management programs not later than December 31, 2002. Requires OMPP to develop a program to control Medicaid expenditures for prescription drugs for Medicaid recipients. Requires OMPP to report to the health finance commission and the budget committee regarding the pharmacy cost control program not later than September 1, 2001. Requires the state's rate setting contractor for nursing home case-mix reimbursement to calculate the median for each case-mix component each quarter using all cost reports received by the state or the state's rate setting contractor within 150 days after each provider's fiscal year end. Provides that a Medicaid recipient may not be denied access to or restricted in the use of a prescription drug for the treatment of a mental illness.

Reprinted
April 12, 2001

First Regular Session 112th General Assembly (2001)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2000 General Assembly.

ENGROSSED
HOUSE BILL No. 1727

A BILL FOR AN ACT concerning health and human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 4-6-10.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 10.5. Public Assistance Programs Investigative Unit

Sec. 1. The attorney general shall establish, within the office of the attorney general, a unit for the investigation of abusive and improper or fraudulent practices in the public assistance programs administered by the office of the secretary of family and social services established by IC 12-8-1-1, including:

(1) the federal food stamp program administered under 7 CFR 277.15;

(2) the Medicaid program administered under IC 12-15; and

(3) cash assistance provided under the temporary assistance for needy families program administered under 45 CFR 260 et seq.

Sec. 2. The investigative unit established by section 1 of this chapter shall investigate:

(1) fraud and abuse on the part of recipients of public assistance under the programs described in section 1 of this chapter; and

(2) potential criminal misconduct by others involved in the administration of the programs.

Sec. 3. If the attorney general determines, following an investigation under this chapter, that a criminal violation may have been committed by any person or entity, the attorney general shall refer the matter to the appropriate prosecuting authority for further action. If invited to do so by the prosecuting authority, the attorney general may participate in the prosecution of a case referred under this subsection.

Sec. 4. If the attorney general determines, following an investigation under this chapter, that misconduct may have occurred on the part of an employee of the state of Indiana, the attorney general may refer the matter to the appropriate agency of the state for potential disciplinary action.

SECTION 2. IC 12-10-10-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] **Sec. 13. (a) The office shall determine whether an individual who is receiving services through the program is eligible to receive services under a Medicaid home and community based waiver (42 U.S.C. 1396 et seq.).**

(b) If the office determines that an individual who is receiving services through the program is eligible to receive services under a Medicaid home and community based waiver:

(1) the individual must be provided services under the waiver; and

(2) the services provided to the individual must be paid for using funds appropriated to the program.

(c) Federal funds received for providing services to an individual under subsection (b) must be used as follows:

(1) Fifty percent (50%) for funding services under the program.

(2) Fifty percent (50%) for funding waiver services.

(d) The division shall assist the office in implementing this section.

SECTION 3. IC 12-15-12-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 13. (a) This section applies to a Medicaid recipient who:**

(1) is determined by the office to be eligible for enrollment in

a Medicaid managed care program; and

(2) resides in a county having:

(A) a population of more than one hundred thousand (100,000), according to the most recently available census information; and

(B) at least two (2) managed care organizations that:

(i) are contracted with the office;

(ii) have an adequate provider network in place, including, at a minimum, a sufficient number of contracted primary medical providers of the appropriate specialty types, as determined by the office; and

(iii) have maintained at least one-third (1/3) of the eligible member enrollment for a continuous period of six (6) months.

(b) The office shall require a recipient described in subsection (a) to enroll in the risk-based managed care program.

(c) The office may adopt rules under IC 4-22-2 to implement this section.

SECTION 4. IC 12-15-26-3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2001](RETROACTIVE)]: **Sec. 3. A recipient under the Medicaid program may not be denied access to or restricted in the use of a prescription drug for the treatment of a mental illness.**

SECTION 5. IC 12-15-26-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2001](RETROACTIVE)]: **Sec. 4. The office and any entity that provides prescription drugs to a Medicaid recipient shall make available to Medicaid recipients prescription drugs that are used for the treatment of a mental illness without any restrictions or limitations, including prior authorization, when the prescription drug is used for the treatment of mental illness.**

SECTION 6. IC 12-15-32-11 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 11. (a) The office may assess community residential facilities for the developmentally disabled (as defined in IC 12-7-2-61) and intermediate care facilities for the mentally retarded (as defined in IC 16-29-4-2) that are not operated by the state in an amount not to exceed ~~five~~ **six** percent ~~(5%)~~ **(6%)** of the annual gross residential services revenue of the facility for the facility's preceding fiscal year.

(b) The assessments shall be paid to the office of Medicaid policy and planning in equal monthly amounts on or before the tenth day of each calendar month. The office may withhold Medicaid payments to

a provider described in subsection (a) that fails to pay an assessment within thirty (30) days after the due date. The amount withheld may not exceed the amount of the assessments due.

(c) Revenue from the assessments shall be credited to a special account within the state general fund to be called the Medicaid assessment account. Money in the account may be used only for services for which federal financial participation under Medicaid is available to match state funds. An amount equivalent to the federal financial participation estimated to be received for services financed from assessments under subsection (a) shall be used to finance Medicaid services provided by facilities described in subsection (a).

(d) If federal financial participation to match the assessments in subsection (a) becomes unavailable under federal law, the authority to impose the assessments terminates on the date that the federal statutory, regulatory, or interpretive change takes effect.

SECTION 7. IC 12-17.6-4-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 7. (a) This section applies to a child who:**

(1) is determined by the office to be eligible for enrollment in a Medicaid managed care program; and

(2) resides in a county having:

(A) a population of more than one hundred thousand (100,000), according to the most recently available census information; and

(B) at least two (2) managed care organizations that:

(i) are contracted with the office;

(ii) have an adequate provider network in place, including, at a minimum, a sufficient number of contracted primary medical providers of the appropriate specialty types, as determined by the office; and

(iii) have maintained at least one-third (1/3) of the eligible member enrollment for a continuous period of six (6) months.

(b) The office shall require a child described in subsection (a) to enroll in the risk-based managed care program.

(c) The office may adopt rules under IC 4-22-2 to implement this section.

SECTION 8. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of the secretary of family and social services established by IC 12-8-1-1.**

(b) As used in this SECTION, "waiver" means a Section 1915(b) freedom of choice waiver under the federal Social Security Act (42

U.S.C. 1315).

(c) Before July 1, 2001, the office shall apply to the United States Department of Health and Human Services for approval of an amendment to the state Medicaid plan or waiver to implement IC 12-15-12-13 and IC 12-17.6-4-7, both as added by this act.

(d) If a provision of this SECTION differs from the requirements of a state plan or waiver amendment, the office shall submit the amendment request in a manner that complies with the requirements of the amendment. However, after the amendment is approved, the office shall apply within one hundred twenty (120) days for an amendment to the approved amendment that contains the provisions of this SECTION that were not included in the approved amendment.

(e) The office may not implement the amended state plan or waiver until the office files an affidavit with the governor attesting that the federal amendment applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the amendment is approved.

(f) If the office receives approval of an amendment under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (e), the office shall implement the amendment not more than sixty (60) days after the governor receives the affidavit.

(g) The office may adopt rules under IC 4-22-2 that are necessary to implement this SECTION.

(h) Notwithstanding IC 12-15-12-13 and IC 12-17.6-4-7, both as added by this act, if an amendment submitted under this SECTION is not approved, the office is not required to implement IC 12-15-12-13 and IC 12-17.6-4-7, both as added by this act.

(i) This SECTION expires July 1, 2005.

SECTION 9. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall develop a disease management program to study the provision of health care services to Medicaid recipients with chronic diseases, the cost of those services, and alternative methods of service delivery to provide the necessary services at a reduced cost.

(c) The office may contract with an outside individual or entity to assist in developing the programs required under subsection (b).

(d) The office shall report to the health finance commission

(IC 2-5-23) and the budget committee not later than December 31, 2002, regarding the programs developed under this SECTION.

(e) This SECTION expires January 1, 2003.

SECTION 10. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall develop a program to control Medicaid expenditures for prescription drugs for recipients.

(c) The office shall report to the health finance commission (IC 2-5-23) and the budget committee not later than September 1, 2001, regarding the program developed under this SECTION.

(d) This SECTION expires December 31, 2001.

SECTION 11. [EFFECTIVE JULY 1, 2001] **(a) The definitions in 405 IAC 1-14.6, as in effect on January 1, 2001, apply throughout this SECTION.**

(b) The state's rate setting contractor shall calculate the median for each rate component each quarter using all cost reports received by the state or the state's rate setting contractor within one hundred fifty (150) days after each provider's fiscal year end. If an audit report has been issued for a provider within one hundred fifty days (150) of the provider's fiscal year end, the rate setting contractor may request additional information relative to that audit report. If the audit report is issued later than one hundred fifty (150) days after the provider's fiscal year end, the rate setting contractor may not request additional information relative to that audit report for that rate review.

SECTION 12. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) As used in this SECTION, "waiver" means a Section 1915(c) waiver under the federal Home and Community-Based Services Program (42 U.S.C. 1396 et seq.).

(c) Before July 1, 2001, the office shall apply to the United States Department of Health and Human Services for the approval necessary to implement IC 12-10-10-13, as added by this act.

(d) The office may not implement IC 12-10-10-13, as added by this act, until the office files an affidavit with the governor that attests that the approval applied for under subsection (c) is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified of the approval.

(e) If the office receives an approval under this SECTION from the United States Department of Health and Human Services and

the governor receives the affidavit filed under subsection (d), the office shall implement IC 12-10-10-13, as added by this act, not more than sixty (60) days after the governor receives the affidavit.

(f) This SECTION expires July 1, 2006.

SECTION 13. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1727, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 4, between lines 10 and 11, begin a new paragraph and insert:

"SECTION 3. IC 12-7-2-24.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: **Sec. 24.5. "Caretaker relative" for purposes of IC 12-17.7, has the meaning set forth in IC 12-17.7-1-2.**".

Page 4, between lines 16 and 17, begin a new paragraph and insert:

"SECTION 4. IC 12-7-2-69 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 69. (a) "Division", except as provided in subsections (b) and (c), refers to any of the following:

(1) The division of disability, aging, and rehabilitative services established by IC 12-9-1-1.

(2) The division of family and children established by IC 12-13-1-1.

(3) The division of mental health established by IC 12-21-1-1.

(b) The term refers to the following:

(1) For purposes of the following statutes, the division of disability, aging, and rehabilitative services established by IC 12-9-1-1:

(A) IC 12-9.

(B) IC 12-10.

(C) IC 12-11.

(D) IC 12-12.

(2) For purposes of the following statutes, the division of family and children established by IC 12-13-1-1:

(A) IC 12-13.

(B) IC 12-14.

(C) IC 12-15.

(D) IC 12-16.

(E) **IC 12-16.1.**

(F) IC 12-17.

~~(F)~~ **(G)** IC 12-17.2.

~~(G)~~ **(H)** IC 12-17.4.

~~(H)~~ **(I)** IC 12-18.

~~(I)~~ **(J)** IC 12-19.

~~(J)~~ **(K)** IC 12-20.

(3) For purposes of the following statutes, the division of mental health established by IC 12-21-1-1:

(A) IC 12-21.

(B) IC 12-22.

(C) IC 12-23.

(D) IC 12-25.

(c) With respect to a particular state institution, the term refers to the division whose director has administrative control of and responsibility for the state institution.

(d) For purposes of IC 12-24, IC 12-26, and IC 12-27, the term refers to the division whose director has administrative control of and responsibility for the appropriate state institution.

SECTION 5. IC 12-7-2-76, AS AMENDED BY P.L.128-1999, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 76. (a) "Eligible individual", for purposes of IC 12-10-10, has the meaning set forth in IC 12-10-10-4.

(b) "Eligible individual" has the meaning set forth in IC 12-14-18-1.5 for purposes of the following:

(1) IC 12-10-6.

(2) IC 12-14-2.

(3) IC 12-14-18.

(4) IC 12-14-19.

(5) IC 12-15-2.

(6) IC 12-15-3.

~~(7) IC 12-16-3.~~

~~(8)~~ **(7)** IC 12-17-1.

~~(9)~~ **(8)** IC 12-20-5.5.".

Page 4, between lines 36 and 37, begin a new paragraph and insert:

"SECTION 7. IC 12-7-2-104.5, AS ADDED BY P.L.128-1999, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 104.5. "Holocaust victim's settlement payment" has the meaning set forth in IC 12-14-18-1.7 for purposes of the following:

(1) IC 12-10-6.

(2) IC 12-14-2

(3) IC 12-14-18.

(4) IC 12-14-19.

(5) IC 12-15-2.

(6) IC 12-15-3.

~~(7) IC 12-16-3.~~

~~(8)~~ **(7)** IC 12-17-1.

~~(9)~~ **(8)** IC 12-20-5.5.

SECTION 8. IC 12-7-2-110, AS AMENDED BY P.L.142-2000, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 110. "Hospital" means the following:

(1) For purposes of IC 12-15-11.5, the meaning set forth in IC 12-15-11.5-1.

(2) For purposes of IC 12-15-18, the meaning set forth in IC 12-15-18-2.

(3) For purposes of ~~IC 12-16, except IC 12-16-1,~~ **IC 12-16.1,** the term refers to a hospital licensed under IC 16-21.

SECTION 9. IC 12-7-2-118.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 118.1. "Inpatient days", for purposes of IC 12-16.1-8, has the meaning set forth in IC 12-16.1-8-1.**

SECTION 10. IC 12-7-2-131.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 131.3. "Minimum data set", for purposes of IC 12-15-41, has the meaning set forth in IC 12-15-41-1.**".

Page 5, between lines 41 and 42, begin a new paragraph and insert:

"SECTION 10. IC 12-7-2-164 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 164. "Resident" has the following meaning:

(1) For purposes of IC 12-10-15, the meaning set forth in IC 12-10-15-5.

(2) For purposes of ~~IC 12-16, except IC 12-16-1,~~ **IC 12-16.1,** an individual who has actually resided in Indiana for at least ninety (90) days.

(3) For purposes of IC 12-20-8, the meaning set forth in IC 12-20-8-1.

(4) For purposes of IC 12-24-5, the meaning set forth in IC 12-24-5-1.

SECTION 11. IC 12-10-12-27 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 27. (a) **Except as provided in subsection (b),** the agency shall, subject to the approval of the division, designate at least one (1) individual who may authorize temporary admittance to a nursing facility under

~~(1) subsection (b); and~~

~~(2)~~ sections 28, 30, and 31 of this chapter

without the approval required under this chapter.

(b) An individual designated under subsection (a) may **not** authorize

temporary admittance to a nursing home **under subsection (a)** for a ~~resident~~ **nonresident** of Indiana. ~~if the resident:~~

~~(1) has received treatment from and is being discharged from a hospital that is located in a state other than Indiana; and~~

~~(2) will be participating in preadmission screening under this chapter.~~

~~(c) Notwithstanding a rule adopted under section 12 of this chapter, a screening team appointed to screen a nonresident under this section must:~~

~~(1) conduct its assessment under section 16 of this chapter; and~~

~~(2) report its findings;~~

~~within ten (10) days after its appointment.~~

SECTION 12. IC 12-15-1-16.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 16.5. Each state department or agency and each local governmental unit shall cooperate with the office who shall conduct a study to examine means in which to cover Medicaid eligible care provided by the departments, agencies, or units with state or local funding.**".

Page 6, line 2, delete "JANUARY 1, 2001" and insert "JULY 1, 2000".

Page 6, line 6, delete "for the period beginning January 1, 2001, through June 30,".

Page 6, line 7, delete "2001, and for".

Page 6, line 7, after "1997," delete "2001" and insert "**2000**".

Page 6, line 21, delete "For the period beginning January 1, 2001,".

Page 6, delete line 22.

Page 6, line 23, delete "June 30, 2001, the" and insert "**The**".

Page 6, line 23, delete "calculate" and insert "**identify**".

Page 6, run in lines 21 and 23.

Page 6, line 25, delete "IC 16-22 or" and insert "**IC 16-22-2, IC 16-22-8, and**".

Page 6, line 26, delete "calculated" and insert "**identified**".

Page 6, line 27, delete ", for the period beginning".

Page 6, delete line 28.

Page 6, line 29, delete "year ending after June 30, 2001,".

Page 6, run in lines 27 and 29.

Page 6, line 31, delete "IC 16-22 or" and insert "**IC 16-22-2, IC 16-22-8, and**".

Page 6, line 34, delete "through" and insert "**and ending**".

Page 6, line 40, after "Subtract the" insert "**amount calculated under**".

Page 6, line 40, after "TWO" delete "amount".

Page 6, line 40, after "from the" insert "**amount calculated under**".

Page 6, line 41, delete "amount".

Page 6, between lines 41 and 42, begin a new line block indented and insert:

"**STEP FIVE: From the amount calculated under STEP FOUR, distribute to a hospital established and operated under IC 16-22-8 an amount equal to one hundred percent (100%) of the difference between:**

(A) the aggregate payments for covered services made under this article to the hospital, excluding payments under IC 12-15-16 and IC 12-15-19; and

(B) a reasonable estimate of the amount that would have been paid for the services described in subdivision (1) under Medicare payment principles.

The actual distribution of the amount calculated under this STEP shall be made pursuant to the terms and conditions provided for the hospital in the state plan for medical assistance.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.".

Page 6, line 42, delete "FIVE" and insert "**SEVEN**".

Page 7, line 1, delete "FOUR" and insert "**SIX**".

Page 7, line 6, reset in roman "each".

Page 7, line 6, delete "the period".

Page 7, delete line 7.

Page 7, line 8, delete "close of a".

Page 7, line 8, delete "ending after June 30, 2001. Payment for".

Page 7, delete line 9.

Page 7, line 10, delete "be made before December 31, 2001." and insert "**Payment for a state fiscal year ending after June 30, 2001, shall be made before December 31 following the state fiscal year's end.**".

Page 7, line 13, delete "IC 16-22" and insert "**IC 16-22-2**".

Page 7, line 18, delete "the period beginning January 1, 2001, through June 30,".

Page 7, line 19, delete "2001, and after the close of".

Page 7, line 19, delete "ending after June" and insert ".".

Page 7, line 20, delete "30, 2001.".

Page 7, line 24, after "fund" insert "**the state's share of payments under this section and**".

Page 7, line 25, after "IC 12-15-20-2(2)" insert ",".

Page 7, line 25, after "and" insert "**payments for the uninsured parents program under**".

Page 7, line 29, delete "FIVE" and insert "**SEVEN**".

Page 7, between lines 38 and 39, begin a new paragraph and insert:

"**(g) For the state fiscal year beginning July 1, 2000, and ending June 30, 2001, the amount calculated under STEP THREE of subsection (b) shall be adjusted to account for the portion of the state fiscal year prior to the effective date of the federal regulation establishing the Medicaid upper payment limit for non-state government owned or operated hospitals at one hundred fifty percent (150%) of Medicare reimbursement rates.**

(h) For purposes of calculating the amount under STEP THREE of subsection (b), the amount attributable to the period of the state fiscal year described in subsection (g) shall be the maximum payment amount available without exceeding the Medicaid upper payment limit applicable for non-state owned or operated hospitals for that period.".

Replace the effective date in SECTION 8 with "[EFFECTIVE JULY 1, 2001]".

Page 8, line 7, delete "." and insert "**and funds available under IC 12-16-14.1-3.**".

Page 9, between lines 8 and 9, begin a new paragraph and insert:

"SECTION 12. IC 12-15-15-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 12. The office may not increase the base amount used to calculate reimbursement rates for inpatient and outpatient hospital services over the base amount used by the office on January 1, 2001.**".

Page 9, between lines 40 and 41, begin a new paragraph and insert:

"SECTION 18. IC 12-15-16-3, AS AMENDED BY P.L.113-2000, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 3. (a) For purposes of disproportionate share eligibility, a provider's low income utilization rate is the sum of the following, based on the most recent year for which an audited cost report is on file with the office:

(1) A fraction (expressed as a percentage) for which:

(A) the numerator is the sum of:

(i) the total Medicaid patient revenues paid to the provider; plus

(ii) the amount of the cash subsidies received directly from state and local governments, including payments made under the hospital care for the indigent program (IC

12-16-2) **(before its repeal);** and

(B) the denominator is the total amount of the provider's patient revenues paid to the provider, including cash subsidies; and

(2) A fraction (expressed as a percentage) for which:

(A) the numerator is the total amount of the provider's charges for inpatient services that are attributable to care provided to individuals who have no source of payment; and

(B) the denominator is the total amount of charges for inpatient services.

(b) The numerator in subsection (a)(1)(A) does not include contractual allowances and discounts other than for indigent patients not eligible for Medicaid.".

Page 12, line 26, delete "JANUARY 1, 2001" and insert "JULY 1, 2000".

Page 12, line 42, delete "for the period before January 1, 2001," and insert "**for the state fiscal years ending on or before June 30, 2000**".

Page 13, delete lines 4 through 28.

Page 13, line 29, delete "(C)" and insert "**(B)**".

Page 13, line 31, delete "2001" and insert "**2000**".

Page 13, line 35, delete "IC 12-15-15-1.1" and insert "**IC 12-15-15-1.1(b)**".

Page 14, line 7, delete "clauses" and insert "**clause**".

Page 14, line 7, delete "and (C)".

Page 14, line 9, delete "disproportionate" and insert "**Medicaid add-on payments to hospitals licensed under IC 16-21 pursuant to a payment methodolgy developed by the office.**".

Page 14, delete line 10, begin a new paragraph and insert:

"SECTION 13. IC 12-15-41 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 41. Annual Review of Medicaid Nursing Facility Residents

Sec. 1. "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, used as:

(1) a comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program; and

(2) a standardized communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies.

Sec. 2. A nursing facility certified to provide nursing facility care to Medicaid recipients shall submit to the office annually minimum data set (MDS) information for each of its Medicaid residents.

Sec. 3. (a) The office or the office's designated contractor shall evaluate the MDS information submitted for each Medicaid resident. The evaluation must consist of an assessment of the following:

(1) The individual's medical needs.

(2) The availability of services, other than services provided in a nursing facility, that are appropriate to the individual's needs.

(3) The cost effectiveness of providing services appropriate to the individual's needs that are provided outside of, rather than within, a nursing facility.

(b) The assessment must be conducted in accordance with rules adopted under IC 4-22-2 by the office.

Sec. 4. If the office determines under section 3 that an individual's needs could be met in a setting other than a nursing facility and in a cost effective manner, the office shall counsel the individual and provide the individual with written notice containing the following:

(1) The reasons for the office's determination.

(2) A detailed description of services available to the individual that, if used by the individual, make the continued placement of the individual in a nursing facility inappropriate.".

Page 14, line 16, delete "2001" and insert "**2002**".

Page 16, line 22, delete "under" and insert "**by**".

Page 16, line 23, delete ":" and insert "**,**".

Page 16, line 24, delete "(1)".

Page 16, line 27, delete "; and" and insert "**.**".

Page 16, run in lines 23 through 27.

Page 16, delete line 28.

Page 16, between lines 28 and 29, begin a new paragraph and insert:

"SECTION 19. IC 12-16.1 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]:

ARTICLE 16.1. HOSPITAL CARE FOR THE INDIGENT

Chapter 1. Applicability

Sec. 1. This article applies only if the office of the uninsured parents program established by IC 12-17.7-2-1 does not implement

an uninsured parents program before July 1, 2003.

Chapter 2. Administration and General Provisions

Sec. 1. The division shall administer the hospital care for the indigent program under this article.

Sec. 2. The division shall adopt necessary forms to be used by the patients, hospitals, physicians, and county offices in carrying out the hospital care for the indigent program.

Sec. 3. The following persons have the same rights and obligations with respect to the hospital care for the indigent program as the persons have with respect to the Medicaid program under IC 12-15-8 and IC 12-15-29:

(1) The division.

(2) Applicants and recipients of assistance.

(3) Insurers.

(4) Persons against whom applicants and recipients of assistance have claims.

(5) The office of Medicaid policy and planning.

Sec. 4. To the extent permitted under federal statutes or regulations, patient days for patients under the hospital care for the indigent program shall be included in calculating allowable disproportionate share additional payments under 42 U.S.C. 1395ww(d).

Sec. 5. The hospital care for the indigent program does not apply to inmates and patients of institutions of the department of correction, the state department of health, the division of mental health, or the division of disability, aging, and rehabilitative services.

Chapter 3. Eligibility for Assistance

Sec. 1. (a) An Indiana resident who meets the income and resource standards established by the division under section 3 of this chapter is eligible for assistance to pay for any part of the cost of care provided in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

(1) Placing the individual's life in jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of a bodily organ or part.

(b) A qualified resident is also eligible for assistance to pay for the part of the cost of care that is a direct consequence of the medical condition that necessitated the emergency care.

Sec. 2. (a) An individual who is not an Indiana resident is

eligible for assistance to pay for the part of the cost of care provided in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

(1) Placing the individual's life in jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(b) An individual is eligible for assistance under subsection (a) only if the following qualifications exist:

(1) The individual meets the income and resource standards established by the division under section 3 of this chapter.

(2) The onset of the medical condition that necessitated medical attention occurred in Indiana.

Sec. 3. (a) The division shall adopt rules under IC 4-22-2 to establish income and resource eligibility standards for patients whose care is to be paid for under the hospital care for the indigent program.

(b) To the extent possible, rules adopted under this section must meet the following conditions:

(1) Be consistent with IC 12-15-21-2 and IC 12-15-21-3.

(2) Be adjusted at least one (1) time every two (2) years.

(c) The income and eligibility standards established under this section do not include any spend down provisions available under IC 12-15-21.

(d) In addition to the conditions imposed under subsection (b), rules adopted under this section must exclude a Holocaust victim's settlement payment received by an eligible individual from the income and eligibility standards for patients whose care is to be paid for under the hospital care for the indigent program.

Sec. 4. A hospital shall provide a patient and, if the patient is not able to understand the statement, the patient's representative with a statement of the eligibility and benefit standards adopted by the division if at least one (1) of the following occurs:

(1) The hospital has reason to believe that the patient may be indigent.

(2) The patient requests a statement of the standards.

Chapter 4. Application for Assistance

Sec. 1. To receive payment from the division for the costs incurred in providing care to an indigent person, a hospital must file an application with the county office of the county in which the hospital is located.

Sec. 2. A hospital must file the application with a county office not more than thirty (30) days after the patient has been admitted to the hospital, unless the patient is medically unable to sign the application and the next of kin or legal representative of the patient is unavailable.

Sec. 3. The division shall adopt rules under IC 4-22-2 prescribing the following:

(1) The form of an application.

(2) The establishment of procedures for applications.

(3) The time for submitting and processing claims.

Sec. 4. The division and a county office shall make application forms available to a hospital upon request.

Sec. 5. A hospital or an attending physician may assist the patient in the preparation of an application for assistance under the hospital care for the indigent program.

Sec. 6. A person who in good faith provides assistance in the completion of an application under this chapter is immune from civil or criminal liability arising from the assistance.

Sec. 7. (a) A patient must sign an application if the patient is medically able to sign.

(b) If a patient is medically unable to sign an application, the patient's next of kin or a legal representative of the patient, if available, may sign the application.

(c) If no person under subsections (a) and (b) is able to sign the application to file a timely application, a hospital representative may sign the application instead of the patient.

Sec. 8. (a) A patient may file an application directly with the county office in the county where the hospital providing care is located if the application is filed not more than thirty (30) days after the patient's admission to the hospital.

(b) Reimbursement for the costs incurred in providing care to an eligible person may only be made to the providers of the care.

Chapter 5. Eligibility Determinations; Investigations

Sec. 1. A county office shall, upon receipt of an application of a patient admitted to a hospital, promptly investigate to determine the patient's eligibility under the hospital care for the indigent program.

Sec. 2. (a) The hospital providing medical care to a patient shall provide information the hospital has that would assist in the verification of indigency of a patient.

(b) A hospital that provides information under subsection (a) is immune from civil and criminal liability for divulging the

information.

Sec. 3. If the division or county office is unable, after prompt and diligent efforts, to verify information contained in the application that is reasonably necessary to determine eligibility, the division or county office may deny assistance under the hospital care for the indigent program.

Sec. 4. The division or county office shall notify, in writing, the patient and the hospital of the following:

(1) A decision concerning eligibility.

(2) The reasons for a denial of eligibility.

(3) That either party has the right to appeal the decision.

Chapter 6. Denial of Eligibility; Appeals; Judicial Review

Sec. 1. If the division or county office determines that a patient is not eligible for payment of medical or hospital care, an affected person may appeal to the division not later than ninety (90) days after the mailing of notice of that determination to the affected person at the person's last known address.

Sec. 2. If the division or county office:

(1) fails to complete an investigation and determination of eligibility under the hospital care for the indigent program within forty-five (45) days after the receipt of the application filed under IC 12-16.1-4; or

(2) fails or refuses to accept responsibility for payment of medical or hospital care under the hospital care for the indigent program;

a person affected may appeal to the division not more than ninety (90) days after the receipt of the application filed under IC 12-16.1-4.

Sec. 3. The division shall fix a time and place for a hearing before a hearing officer appointed by the director of the division.

Sec. 4. A notice of the hearing shall be served upon all persons interested in the matter at least twenty (20) days before the time fixed for the hearing.

Sec. 5. (a) Following the hearing, the division shall determine the eligibility of the person for payment of the cost of medical or hospital care under the hospital care for the indigent program.

(b) If the person is found eligible, the division shall pay the reasonable cost of the care to the persons furnishing the care, subject to the limitations in IC 12-16.1-7.

Sec. 6. A person aggrieved by a determination under section 5(a) of this chapter may appeal the determination under IC 4-21.5.

Sec. 7. (a) The division shall adopt rules under IC 4-22-2 that

provide for an administrative appeal procedure that is responsive to the needs of patients and providers.

(b) The procedure must provide for the following:

(1) The location of hearings.

(2) The presentation of evidence.

(3) The use of telecommunications.

Chapter 7. Cost of Care and Payment

Sec. 1. The division shall pay the following, subject to the limitations in section 4 of this chapter:

(1) The necessary costs of medical or hospital care for indigent patients.

(2) The cost of transportation to the place of treatment arising out of the medical or hospital care for indigent patients.

Sec. 2. (a) Except as provided in section 5 of this chapter, claims for payment shall be segregated by year using the patient's admission date.

(b) Each year, the division shall pay claims as provided in section 4 of this chapter without regard to the county of admission or that county's transfer to the state fund.

Sec. 3. A payment made to a hospital under the hospital care for the indigent program must be on a warrant drawn on the state hospital care for the indigent fund established under IC 12-16-14.

Sec. 4. (a) Each year, the division shall pay two-thirds (2/3) of each claim upon submission and approval of the claim.

(b) If the amount of money in the state hospital care for the indigent fund in a year is insufficient to pay two-thirds (2/3) of each approved claim for patients admitted in that year, the state's and a county's liability to providers under the hospital care for the indigent program for claims approved for patients admitted in that year is limited to the sum of the following:

(1) The amount transferred to the state hospital care for the indigent fund from county hospital care for the indigent funds in that year under IC 12-16.1-14.

(2) Any contribution to the fund in that year.

(3) Any amount that was appropriated to the state hospital care for the indigent fund for that year by the general assembly.

(4) Any amount that was carried over to the state hospital care for the indigent fund from a preceding year.

(c) This section does not obligate the general assembly to appropriate money to the state hospital care for the indigent fund.

Sec. 5. Before the end of each state fiscal year, the division shall,

to the extent there is money in the state hospital care for the indigent fund, pay each provider under the hospital care for the indigent program a pro rata part of the one-third (1/3) balance on each approved claim for patients admitted during the preceding year.

Sec. 6. If:

(1) a claim for a patient admitted during a particular year is not submitted by the deadline established by the division; and

(2) the failure to submit the claim is not the fault of the provider;

the claim shall be considered a claim for the year the claim is submitted for purposes of payment under this chapter.

Sec. 7. The division and a county office are not responsible under the hospital care for the indigent program for the payment of any part of the costs of providing care in a hospital to an individual who is not either of the following:

(1) A citizen of the United States.

(2) A lawfully admitted alien.

Sec. 8. The division and a county office are not liable for any part of the cost of care provided to an individual who has been determined to be a patient described in the rules adopted under IC 12-16.1-10.

Sec. 9. IC 12-16.1-2 through IC 12-16.1-16 do not affect the liability of a county with respect to claims for hospital care for the indigent for patients admitted before January 1, 1987.

Sec. 10. (a) The budget agency shall estimate for each fiscal year the cost savings to the state hospital care for the indigent fund as the result of the provision of Medicaid to an individual described in IC 12-15-2-12 and IC 12-15-2-13.

(b) The budget agency shall, each fiscal year, recommend to the general assembly that an amount equal to the cost savings described in subsection (a) be transferred from the state hospital care for the indigent fund to the state general fund.

Sec. 11. Providers eligible for payment under IC 12-15-15-9 may not receive payment under this chapter.

Sec. 12. All providers receiving payment under this chapter agree to accept, as payment in full, the amount paid for the hospital care for the indigent program for those claims submitted for payment under the program, with the exception of authorized deductibles, co-insurance, co-payment, or similar cost sharing charges.

Chapter 8. Disproportionate Share Providers

Sec. 1. As used in this chapter, "inpatient days" includes:

(1) days provided by an acute care subunit of the provider; and

(2) inpatient days attributable to Medicaid and hospital care for the indigent beneficiaries from other states.

Sec. 2. A payment adjustment consisting of an additional percentage payment for each service paid under the hospital care for the indigent program made to a disproportionate share hospital licensed under IC 16-21 that meets the requirements under section 3 of this chapter.

Sec. 3. A provider is a disproportionate share hospital if the provider's Medicaid inpatient utilization rate is at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana.

Sec. 4. A provider's Medicaid inpatient utilization rate is a fraction (expressed as a percentage) in which:

(1) the numerator is the provider's total number of Medicaid and health care for the indigent inpatient days in a cost reporting period; and

(2) the denominator is the total number of the provider's inpatient days in that same period.

Sec. 5. A disproportionate share hospital must receive a twenty percent (20%) adjustment for each service.

Chapter 9. Rate of Payment

Sec. 1. The rate of payment for the services and materials provided by hospitals and physicians under the hospital care for the indigent program is the same rate as payment for the same type of services and materials under the rules adopted by the secretary under Medicaid.

Chapter 10. Rules

Sec. 1. The division shall, with the advice of the division's medical staff, the division of mental health, the division of disability, aging, and rehabilitative services, and other individuals selected by the director of the division, adopt rules under IC 4-22-2 to do the following:

(1) Provide for review and approval of services paid under the hospital care for the indigent program.

(2) Establish limitations consistent with medical necessity on the duration of services to be provided.

(3) Specify the amount of and method for reimbursement for services.

(4) Specify the conditions under which payments will be

denied and improper payments will be recovered.

Sec. 2. To the extent possible, rules adopted under section 1 of this chapter must be consistent with IC 12-15-21-2 and IC 12-15-21-3.

Sec. 3. The rules adopted under section 1 of this chapter must include rules that will deny payment for services provided to a patient after the patient is medically stable and can safely be discharged.

Sec. 4. (a) The division shall adopt rules under IC 4-22-2 necessary to establish a statewide collection system of data concerning the hospital care for the indigent program.

(b) The following data must be collected:

(1) Patient demographics.

(2) Types of services provided by hospitals.

(3) Costs of particular types of services provided by hospitals.

(c) A hospital that provides services under the hospital care for the indigent program shall file copies of all claims submitted under the program with the contractor engaged by the division to adjudicate claims.

Sec. 5. The division may adopt rules under IC 4-22-2 that are in addition to and consistent with the rules required to be adopted under IC 12-16.1-6 governing appeals brought under the hospital care for the indigent program to the division.

Chapter 11. Recovery of Payments by Division

Sec. 1. The division may recover amounts paid under the hospital care for the indigent program by the division from the following:

(1) A patient approved for assistance.

(2) A person legally responsible for those patients approved for assistance.

(3) The estate of the patient or person.

Sec. 2. The division is subrogated, to the extent of the assistance given by the division, to the rights that a patient receiving assistance under the hospital care for the indigent program has against any other person who is in any part liable for the illness or injury for which assistance was granted.

Chapter 12. County With Health and Hospital Corporation; Responsibility for Medical Cost

Sec. 1. This chapter applies to a county having a health and hospital corporation created under IC 16-22-8-6.

Sec. 2. The division is responsible for the emergency medical care given in a hospital to an individual who qualifies for assistance

under this chapter, subject to the limitations in IC 12-16.1-7.

Sec. 3. The hospital providing care shall transfer the patient to a hospital operated by the health and hospital corporation as soon as the attending physician determines that the patient's medical condition permits the transfer without risk of injury to the patient.

Sec. 4. (a) If a hospital owned by the health and hospital corporation is:

(1) unable to care for a patient; or

(2) unable to treat a patient at the time a transfer is requested by the hospital initiating treatment;

the hospital initiating treatment may continue to treat the patient until the patient's discharge.

(b) Subject to the limitations in IC 12-16.1-7, the division shall pay the costs of care.

Sec. 5. The division is not responsible for the following:

(1) The payment of nonemergency medical costs, except as provided under the hospital care for the indigent program.

(2) The payment of medical costs accrued at a hospital owned or operated by a health and hospital corporation, except for hospital care provided under this chapter to a person not residing in Marion County.

Chapter 13. Immunity

Sec. 1. A hospital, a physician, or an agent or employee of a hospital or physician that provides services in good faith under the hospital care for the indigent program is immune from liability to the extent the liability is attributable to at least one (1) of the following:

(1) The requirement that a patient be transferred under IC 12-16.1-12.

(2) The denial of payment under IC 12-16.1-10.

Sec. 2. Section 1(1) of this chapter does not limit liability for the determination that the patient's medical condition permits a transfer under IC 12-16.1-12.

Chapter 14. Property Tax Levy and Funds

Sec. 1. A county hospital care for the indigent fund is established in each county. The fund consists of the following:

(1) A tax levy on the property located in each county.

(2) The financial institutions tax (IC 6-5.5), motor vehicle excise taxes (IC 6-6-5), and commercial vehicle excise taxes (IC 6-6-5.5) that are allocated to the fund.

Sec. 2. (a) The tax required by section 1(1) of this chapter shall be imposed annually by the county fiscal body on all of the taxable

property of the county.

(b) The tax shall be collected as other state and county ad valorem property taxes are collected.

Sec. 3. Each county shall impose a hospital care for the indigent tax levy equal to the product of:

(1) the most recent hospital care for the indigent property tax levied by the county; multiplied by

(2) the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this section will be first due and payable.

Sec. 4. The state board of tax commissioners shall review each county's property tax levy under this chapter and shall enforce the requirements of this chapter with respect to that levy.

Sec. 5. All receipts derived from the tax levy shall be paid into the county general fund and constitute the county hospital care for the indigent fund.

Sec. 6. (a) The state hospital care for the indigent fund is established.

(b) Before the fifth day of each month, all money contained in a county hospital care for the indigent fund at the end of the preceding month shall be transferred to the state hospital care for the indigent fund.

Sec. 7. (a) The state hospital care for the indigent fund consists of the following:

(1) Money transferred to the state hospital care for the indigent fund from the county hospital care for the indigent funds.

(2) Any contributions to the fund from individuals, corporations, foundations, or others for the purpose of providing hospital care for the indigent.

(3) Money advanced to the fund under IC 12-16.1-15.

(4) Appropriations made specifically to the fund by the general assembly.

(b) This section does not obligate the general assembly to appropriate money to the state hospital care for the indigent fund.

Sec. 8. The division shall administer the state hospital care for the indigent fund and shall use the money currently in the fund to defray the expenses and obligations incurred by the division for hospital care for the indigent. The money in the fund is hereby appropriated.

Sec. 9. Money in the state hospital care for the indigent fund at

the end of a state fiscal year remains in the fund and does not revert to the state general fund.

Chapter 15. Advancements From State Fund

Sec. 1. The division may request an advancement of money from the state general fund in anticipation of county property tax revenue being transferred to the state hospital care for the indigent fund.

Sec. 2. (a) The budget director shall determine an interest rate that is at least the interest rate earned by the state on investments made from money in the state general fund.

(b) The interest rate shall be paid on the amount that is advanced from the state general fund.

Sec. 3. The amount that may be advanced, plus the projected interest on that amount, may not exceed the amount of county property tax revenue that is expected to be transferred to the state hospital care for the indigent fund during the six (6) months following the date of the request.

Sec. 4. A request for an advancement must be submitted to the budget agency.

Sec. 5. The state board of finance may, on the recommendation of the director of the budget agency, approve an advancement.

Sec. 6. If an advancement is approved, the county property tax revenue transferred to the state hospital care for the indigent fund shall be immediately used to repay the amount of the interest and advancements made under this section.

Chapter 16. Review of Medical Criteria

Sec. 1. The division shall review changes made after 1985 in the medical criteria used to establish whether a patient is eligible for assistance under IC 12-16.1-3.

Sec. 2. The division's review under this chapter must include the application of the criteria to specific cases and address whether changes to or clarification of the criteria is necessary so that, in practice, the criteria are consistent with the hospital care for the indigent program.

Sec. 3. The division shall provide to an interested party a report of the division's review, including the division's findings, conclusions, and recommendations.".

Page 16, between lines 35 and 36, begin a new paragraph and insert:

"**Sec. 2. (a) "Caretaker relative" means a blood relative and those of half blood.**

(b) The term includes an adoptive parent, grandparent, sibling, and a relative of an adoptive parent.

(c) The term also includes a spouse of an individual described in subsection (b), even after the marriage is terminated by death or dissolution.".

Page 16, line 36, delete "2." and insert "**3.**".

Page 17, line 5, delete "3." and insert "**4.**".

Page 17, line 7, delete "4." and insert "**5.**".

Page 18, line 21, delete "parent" and insert "**caretaker relative**".

Page 19, between lines 30 and 31, begin a new paragraph and insert:

"**Sec. 4. (a) The office shall offer health insurance coverage for the following additional services if the coverage for the services has an actuarial value equal to or greater than the actuarial value of the services provided by the benchmark program determined by the children's health policy board established by IC 4-23-27-2:**

(1) Prescription drugs.

(2) Mental health services.

(3) Vision services.

(4) Hearing services.

(5) Dental services.

(b) The office may not impose treatment limitations or financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses.".

Page 19, line 31, delete "4." and insert "**5.**".

Page 19, line 33, delete "5." and insert "**6.**".

Page 20, line 18, delete "has" and insert "**shall have**".

Page 22, line 5, delete "not" and insert "**only**".

Page 22, line 5, delete "any person" and insert "**the following:**

(1) Another provider involved or potentially involved in the care of the individual.

(2) A person who:

(A) works under the authority of a provider described in subdivision (1); and

(B) requires the information for the provider's legitimate business or clinical purposes.".

Page 22, between lines 15 and 16, begin a new paragraph and insert:

"**Sec. 1. This chapter applies beginning July 1, 2002.**".

Page 22, line 16, delete "1" and insert "**2**".

Page 22, line 29, delete "2" and insert "**3**".

Page 22, line 29, delete "1(a)(1)" and insert "**2(a)(1)**".

Page 22, line 34, delete "1(a)(1)" and insert "**2(a)(1)**".

Page 22, line 37, delete "3" and insert "**4**".

Page 22, line 37, delete "sections 4 and 5" and insert "**sections 5**

and 6".

Page 22, line 37, delete "section 5" and insert "**section 6**".

Page 22, line 42, after "equal" insert "**ninety percent (90%) of**".

Page 23, line 9, after "equal" insert "**ninety percent (90%) of**".

Page 23, line 27, delete "4" and insert "**5**".

Page 24, line 14, delete "3(3)" and insert "**4(3)**".

Page 24, line 15, delete "5" and insert "**6**".

Page 25, line 2, delete "3(3)" and insert "**4(3)**".

Page 25, line 3, delete "6" and insert "**7**".

Page 25, line 6, delete "7" and insert "**8**".

Page 26, between lines 39 and 40, begin a new paragraph and insert:

"SECTION 26. IC 34-30-2-45.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 45.5. IC 12-16.1-4-6 (Concerning persons who aid a patient in completing an application for assistance under the hospital care for the indigent program).**

SECTION 27. IC 34-30-2-45.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 45.7. IC 12-16.1-5-2 (Concerning hospitals for providing information verifying indigency of patient).**

SECTION 28. IC 34-30-2-45.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 45.9. IC 12-16.1-13-1 (Concerning hospitals or persons providing services under the hospital care for the indigent program).**".

Page 27, delete lines 19 through 23.

Page 27, line 24, after "19." insert "IC 12-10-12-27.1; IC 12-10-12-28.5".

Page 27, between lines 27 and 28, begin a new paragraph and insert:

"SECTION 30. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2002]: IC 12-7-2-118; IC 12-16-2; IC 12-16-3; IC 12-16-4; IC 12-16-5; IC 12-16-6; IC 12-16-7; IC 12-16-8; IC 12-16-9; IC 12-16-10; IC 12-16-11; IC 12-16-12; IC 12-16-13; IC 12-16-15; IC 12-16-16; IC 34-30-2-44; IC 34-30-2-45; IC 34-30-2-45.3.".

Page 27, line 28, delete "JUNE 30" and insert "JULY 1".

Page 27, delete lines 36 through 42.

Page 28, delete lines 1 through 3.

Page 28, between lines 26 and 27, begin a new paragraph and insert:

"**(e) Notwithstanding subsection (d), the office shall not in any event implement the state plan amendment and waiver:**

(1) before July 1, 2002; and

(2) before requisite funds for the program's implementation are available or projected to be available, as determined by the office.".

Page 28, line 27, delete "(e)" and insert "**(f)**".

Page 28, line 32, delete "(f)" and insert "**(g)**".

Page 28, line 41, delete "(g)" and insert "**(h)**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1727 as introduced.)

BAUER, Chair

Committee Vote: yeas 22, nays 1.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1727 be amended to read as follows:

Page 4, line 13, after "relative"" insert "**,**".

Page 9, line 14, after "(b)" insert "For".

Page 17, line 23, after "2000" insert "**,**".

Page 17, line 42, delete "(D)" and insert "**(C)**".

Page 39, line 26, after "equal" insert "**to**".

Page 39, line 26, after "of" delete "to".

Page 39, line 36, after "equal" insert "**to**".

Page 39, line 36, after "of" delete "to".

Page 44, delete lines 19 through 20, begin a new paragraph and insert:

"SECTION 35. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2001]: IC 12-10-12-27.1; IC 12-10-12-28.5; IC 12-15-19-10.1.".

(Reference is to HB 1727 as printed February 15, 2001.)

CRAWFORD

HOUSE MOTION

Mr. Speaker: I move that House Bill 1727 be amended to read as follows:

Page 4, line 20, delete "IC 12-17.7-1-2." and insert "**IC 12-17.7-1-3.**".

Page 7, line 16, delete "IC 12-17.7-1-3." and insert "**IC 12-17.7-1-4.**".

Page 7, line 28, delete "IC 12-17.7-1-4." and insert "**IC 12-17.7-1-5.**".

(Reference is to HB 1727 as printed February 15, 2001.)

CRAWFORD

COMMITTEE REPORT

Mr. President: The Senate Committee on Finance, to which was referred House Bill No. 1727, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Delete the title and insert the following:

A BILL FOR AN ACT concerning health and human services.

Delete everything after the enacting clause and insert the

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to HB 1727 as reprinted February 20, 2001.)

BORST, Chairperson

Committee Vote: Yeas 12, Nays 2.

SENATE MOTION

Mr. President: I move that Engrossed House Bill 1727 be amended to read as follows:

Page 2, delete lines 18 through 26.

Renumber all SECTIONS consecutively.

(Reference is to EHB 1727 as printed April 6, 2001.)

JOHNSON

SENATE MOTION

Mr. President: I move that Engrossed House Bill 1727 be amended to read as follows:

Page 2, between lines 26 and 27, begin a new paragraph and insert:

"SECTION 3. IC 12-10-10-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] **Sec. 13. (a) The office shall determine whether an individual who is receiving services through the program is eligible to receive services under a Medicaid home and community based waiver (42 U.S.C. 1396 et seq.).**

(b) If the office determines that an individual who is receiving services through the program is eligible to receive services under a Medicaid home and community based waiver:

(1) the individual must be provided services under the waiver; and

(2) the services provided to the individual must be paid for using funds appropriated to the program.

(c) Federal funds received for providing services to an individual under subsection (b) must be used as follows:

(1) Fifty percent (50%) for funding services under the program.

(2) Fifty percent (50%) for funding waiver services.

(d) The division shall assist the office in implementing this section.".

Page 6, between lines 2 and 3, begin a new paragraph and insert:

"SECTION 11. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) As used in this SECTION, "waiver" means a Section 1915(c) waiver under the federal Home and Community-Based Services

Program (42 U.S.C. 1396 et seq.).

(c) Before July 1, 2001, the office shall apply to the United States Department of Health and Human Services for the approval necessary to implement IC 12-10-10-13, as added by this act.

(d) The office may not implement IC 12-10-10-13, as added by this act, until the office files an affidavit with the governor that attests that the approval applied for under subsection (c) is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified of the approval.

(e) If the office receives an approval under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (d), the office shall implement IC 12-10-10-13, as added by this act, not more than sixty (60) days after the governor receives the affidavit.

(f) This SECTION expires July 1, 2006.".

Renumber all SECTIONS consecutively.

(Reference is to EHB 1727 as printed April 6, 2001.)

ALEXA

SENATE MOTION

Mr. President: I move that Engrossed House Bill 1727 be amended to read as follows:

Page 3, between lines 7 and 8, begin a new paragraph and insert:

SECTION 4. IC 12-15-26-3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2001](RETROACTIVE)]: **Sec. 3. A recipient under the Medicaid program may not be denied access to or restricted in the use of a prescription drug for the treatment of a mental illness.**

SECTION 5. IC 12-15-26-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2001](RETROACTIVE)]: **Sec. 4. The office and any entity that provides prescription drugs to a Medicaid recipient shall make available to Medicaid recipients prescription drugs that are used for the treatment of a mental illness without any restrictions or limitations, including prior authorization, when the prescription drug is used for the treatment of mental illness.**

Renumber all SECTIONS consecutively.

(Reference is to Engrossed House Bill as printed April 6, 2001.)

SIMPSON